STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155793	A. BUILDING _____ B. WING _____	C 12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON TRACE OF FISHERS	**11851 CUMBERLAND RD FISHERS, IN 46037**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints #IN00159424 & #IN00160809. Complaint #IN00159424- Unsubstantiated due to lack of evidence. Complaint #IN00160809- Unsubstantiated due to lack of evidence. Survey dates: December 18 & 19, 2014 Facility number: 012644 Provider number: 155793 AIM number: 201046710 Survey team: Michelle Carter, RN Census bed type: SNF- 32 SNF/NF- 66 Residential- 31 Total- 129 Census payor type: Medicare- 29 Medicaid- 28 Other- 6 Total- 63 Sample - 6 Hamilton Trace of Fishers was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints #IN00159424 & #IN00160809.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Quality Review 12/29/14 by Lisa McColly	F 000		